CFS 431-A
Rev 05/2024

Illinois Department of Children & Family Services
PSYCHOTROPIC MEDICATION REQUEST FORM
Fax completed form to 312-814-7015

Date of Request _____

YOUTH INFORMATION

Last Name_____ First Name_____ Middle ____ Suffix ___ Pronouns: _____

DCFS ID# (8digits) __ __ __ __ __ __ __ __ Date of Birth _____ Sex at Birth: ☐Male ☐Female ☐Intersex

Placement type: ☐Foster Home ☐ Parent(s) ☐Shelter ☐Residential (QRTP) ☐Hospital ☐Detention ☐IYC ☐Other _____

PRESCRIBER INFORMATION

Last Name_____ First Name_____ Specialty_____ Phone*_____

*For expedited processing, please include prescriber's cell phone, or direct line to medical staff.

Completed consent to be sent to: Fax _____ ***and*** Email _____

Form Completed by: ☐ Prescriber's office ☐ Facility Staff ☐ Other _____

Last Name_____ First Name_____ Phone _____ Facility/Agency Name: _____

CLINICAL INFORMATION

List of Psychiatric Diagnoses (Indicate Rule Out & History of):
Medical Diagnoses:
Medical/OTC Medications:
Weight (lbs) : Height (ft/in) : Date taken:
Weight related plan (required for <10% or >90% BMI):

CURRENT PSYCHOTROPIC MEDICATIONS

Is the youth currently on any Psychotropic Medication? Yes ☐ No ☐

List current psychotropic medications & dosages, including meds to treat side effects, meds without consent, and those being renewed.

Medication	Dose	Times Given	Will or has med been Discontinued?	Discontinued Reason	Taper Schedule
			☐ Yes		
			☐ Yes		
			☐ Yes		
			☐ Yes		
			☐ Yes		
			☐ Yes		
			☐ Yes		

MEDICATION REQUEST (ALL fields required for processing)

Side effects of all requested medications reviewed with youth? ☐ **YES** ☐ **NO**

Does youth object? ☐ **YES** ☐ **NO** _____

IF YES, LIST MEDICATION AND EXPLAIN WHY CHILD OBJECTS

Type of request: ☐New ☐Increase ☐Renewal (consent to expire) ☐New to DCFS, continuing med ☐One time emergency med (for acute sx)
☐On med or dosage w/o consent, Prescriber who started /increased med _____ **Date started** _____

Medication_____ Dose_____ Time Given_____ Max daily range _____ Form_____ Duration_____

NOT TO EXCEED 180 DAYS

List specific symptoms (NOT diagnoses) that are **Current**: _____

List specific symptoms (NOT diagnoses) that are **Controlled with Med**: _____

Additional rationale for co-pharmacy, non-first-line medications, polypharmacy and other significant clinical information i.e. explanation of treatment plan or history, etiology of sleep disturbance, **alternative treatments (required for children <6)**.

Annual screening labs required for all youth taking antipsychotic and/or mood stabilizer medications.

Labs attached? ☐ Yes ☐ No If no, date of lab submission _____

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Page 2 (not to be sent without page 1)

Youth's name _____ DCFS ID#__ __ __ __ __ __ __ __

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